

Basic Medicaid

Billing Guide

October 2008



Section 1. Who's Who in Medicaid1-1

What Is Medicaid?	1-1
Centers for Medicare and Medicaid Services	1-1
Department of Health and Human Services.....	1-1
Division of Medical Assistance.....	1-1
Department of Social Services.....	1-1
Electronic Data Systems.....	1-2
Piedmont Cardinal Health Plan.....	1-2
Division of Medical Assistance: Organization Roles	1-2
Recipient and Provider Services.....	1-2
Clinical Policy and Programs	1-2
Managed Care	1-4
Quality, Evaluation, and Health Outcomes	1-5
Finance Management	1-5
Budget Management.....	1-5
Program Integrity	1-7

Section 2. Recipient Eligibility2-1

Eligibility Determination.....	2-1
Eligibility Categories.....	2-1
When Does Eligibility Begin?	2-2
Retroactive Eligibility.....	2-2
Eligibility Reversals	2-3
Medicaid Identification Cards.....	2-3
Blue and Pink Medicaid Identification Card Information.....	2-4
Blue Medicaid Identification Card.....	2-5
Family Planning Waiver	2-6
Piedmont Cardinal Health Plan Card	2-9
Pink Medicaid Identification Card.....	2-10
Buff MEDICARE-AID ID Card	2-11
Buff MEDICARE-AID ID Card Information	2-11
County-Issued Medicaid Identification Cards.....	2-13
Program of All-Inclusive Care for the Elderly	2-13
Verifying Eligibility	2-13
Verification Methods	2-15
Transfer of Assets.....	2-15
Services Included in the Transfer of Assets Policy	2-15
Medicaid Recipients Subject to the Policy	2-16
Transfer of Assets Determination.....	2-16
Provider Access to Transfer of Assets Information	2-16

Eligibility Denials	2-17
Step 1—Check for Errors on the Claim	2-17
Step 2—Check for Data Entry Errors	2-17
Step 3—When All Information Matches	2-17
Explanation of Benefits (EOBs) for Eligibility Denials.....	2-18
Annual Visit Limitation.....	2-20
Mandatory Services	2-20
Optional Services.....	2-21
CPT Procedure Codes Subject to the Annual Visit Count.....	2-21
Recipients Who Are Not Subject to the Annual Visit Limitation.....	2-21
Requesting an Exemption.....	2-21
Copayments.....	2-21
Copayment Exemptions.....	2-23
EPSDT Policy Instructions Update.....	2-23
Background.....	2-23
EPSDT Features.....	2-24
EPSDT Criteria	2-26
Important Points about EPSDT Coverage	2-27
Procedure for Requesting EPSDT Services	2-34
For Further Information about EPSDT	2-36
Attachments	2-36
Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].....	2-37

Section 3. Medicaid Provider Information3-1

Enrollment Procedure	3-1
Providers will be assigned a Medicaid provider number and will be notified by mail once the process has been completed.....	3-1
Group Provider Enrollment Packets.....	3-1
Individual Provider Enrollment Packets.....	3-1
Qualifications for Enrollment	3-1
Licensure	3-1
Service Location	3-2
Provider Agreements	3-2
Attestation Letter.....	3-2
Tax Information	3-2
Conditions of Participation	3-3
Civil Rights Act.....	3-3
Rehabilitation and Disabilities Acts	3-3
Disclosure of Medicaid Information	3-4

Medical Record Documentation	3-4
Payment in Full	3-5
Provider Forms	3-5
Fee Schedule Requests.....	3-5
Provider Responsibilities.....	3-6
Verifying Recipient Eligibility	3-6
Missed Appointments.....	3-6
Billing the Recipient	3-6
Third-Party Liability	3-7
Overpayments.....	3-7
Reporting Provider Changes.....	3-7
What Changes Must Be Reported	3-7
How to Report a Change	3-9
Voluntary Termination.....	3-10
Termination of Inactive Providers.....	3-10
Payment Suspension	3-10
Licensure Revocation or Suspension.....	3-10
Sanctions	3-11
Program Integrity Reviews.....	3-11
Determining Areas for Review	3-11
Provider Responsibilities in a Program Integrity Review.....	3-12
Request for Reconsideration	3-12
Self-Referral Federal Regulation.....	3-13
Advance Directives	3-13
Provider Information—Frequently Asked Questions	3-14
Section 4. Managed Care Provider Information	4-1
Community Care of North Carolina—Carolina ACCESS	4-1
Carolina ACCESS.....	4-1
Community Care of North Carolina—ACCESS II/III.....	4-1
Recipient Enrollment.....	4-2
Recipient Education	4-4
Provider Participation.....	4-4
Requirements for Participation.....	4-4
Conditions of Participation	4-7
Exceptions	4-8
Sanctions	4-8
Sanction Appeals	4-8
Terminations	4-9
Provider Reports	4-9

Enrollment Report	4-9
Emergency Room Management Report.....	4-9
Referral Report	4-9
Quarterly Utilization Report.....	4-10
Provider Requirements	4-10
Health Check Services.....	4-10
Adult Preventive Annual Health Assessments	4-10
24-Hour Coverage	4-10
Standards of Appointment Availability.....	4-11
Standards for Office Wait Times	4-12
Hospital Admitting Privileges	4-12
Women, Infants, Children Special Supplemental Nutrition Program Referrals	4-13
Transfer of Medical Records	4-13
Medical Records Guidelines	4-13
Referrals and Authorizations.....	4-14
Referrals for a Second Opinion.....	4-15
Referral Documentation	4-15
Submitting Referral Claims	4-15
Exempt Services	4-16
Override Requests	4-17
Medical Exemption Requests	4-17
Patient Disenrollment.....	4-18
Carolina ACCESS—Frequently Asked Questions	4-19
Calling the AVR system	4-19
Checking the current Carolina ACCESS Enrollment Report	4-19
Modified Sample of Carolina ACCESS Provider Enrollment Report, Section 1, New Enrollees.....	4-22
Modified Example of Carolina ACCESS Provider Enrollment Report, Section 2, Current Enrollees	4-23
Modified Example of Carolina ACCESS Provider Enrollment Report, Section 3, Terminated Enrollees.....	4-24
Example of Emergency Room Management Report.....	4-25
Example of Referral Report	4-26
INSTRUCTIONS FOR QUARTERLY UTILIZATION REPORT	4-27
List of Regional Managed Care Consultants.....	4-30
Section 5. Submitting Claims to Medicaid.....	5-1
Time Limits for Filing Claims	5-1
Submitting Claims Electronically	5-1
Submitting Claims on Paper	5-1

Processing Paper Claims without a Signature	5-2
National Drug Code	5-2
Billing Professional (CMS-1500/837P) Claims	5-3
Modifiers	5-3
Instructions for Billing Professional Claims	5-4
Definitions	5-4
Quick Reference Guides for Carolina ACCESS Providers.....	5-6
Quick Reference Guides for Carolina ACCESS Providers.....	5-7
Professional Claims Processed with CA PCP Authorization	5-7
Professional Claims Processed with CA Override	5-7
Billing Institutional (UB-04/837I) Claims.....	5-9
Instructions for Billing Institutional Claims.....	5-9
Definitions	5-9
Quick Reference Guides for Carolina ACCESS Providers.....	5-12
Quick Reference Guides for Carolina ACCESS Providers.....	5-13
Institutional Claims Processed with CA PCP Authorization	5-13
Institutional CA Claims Processed with CA Override Number	5-14
Billing Dental (ADA 2006/837D) Claims.....	5-15
Definitions	5-15
Billing Pharmacy Claims	5-18
Medicare Crossover Claims.....	5-18
Copayments.....	5-19
Carolina ACCESS Primary Care Providers.....	5-20
Prior Approval	5-20
Annual Visit Limitation.....	5-20
Hysterectomy, Sterilization, and Abortion Consents/Statement.....	5-20
Durable Medical Equipment Span Dates	5-20
Optical Refractions.....	5-20
Reimbursement Guidelines.....	5-20
Professional or Dental Claim Denials for Non-covered Services	5-22
Medicare Health Maintenance Organization	5-24
Professional Services	5-24
HMO example of CMS-1500 claim form without third party insurance, HMO EOB attached:	5-24
Institutional Services	5-25
HMO example of UB-04 claim form, HMO EOB attached.....	5-26
Section 6. Prior Approval	6-1
Important Points about Prior Approval	6-2
Early and Periodic Screening, Diagnostic and Treatment.....	6-5

General Requests for Prior Approval	6-8
Denial of Prior Approval	6-8
Requests for Specific Types of Prior Approval.....	6-9
Adult Care Home – Enhanced Care.....	6-9
Adult Care Home – Special Care Unit for Persons with Alzheimer’s and Related Disorders	6-9
Augmentative and Alternative Communication Devices.....	6-9
Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair	6-9
Community Alternatives Program Participation.....	6-10
Dental Services.....	6-11
Hearing Aids, Frequency Modulation Systems, and Accessories	6-12
Hospice Participation	6-12
Long-Term-Care Services.....	6-13
Optical Services—Routine Eye Exams with Refractions.....	6-13
Optical Services—Visual Aids.....	6-13
Oral Nutrition Products.....	6-13
Out-of-State or State-to-State Ambulance Service	6-14
Outpatient Specialized Therapies	6-14
Over-the-Counter Medications	6-14
Prescription Drugs	6-15
Transplants	6-15
Utilization Review for Psychiatric Services	6-17
<i>Quick Reference Table—Prior Approval for Certain Medicaid Services</i>	<i>6-18</i>
<i>Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].....</i>	<i>6-26</i>
Section 7. Third-Party Insurance	7-1
Third Party Liability – Commercial Health Insurance and Medicare – Medicaid Payment Guidelines for Third Party Coverage.....	7-1
Services Provided to Medicare-Eligible Medicaid	7-1
Contracted Fee-for-Service Payments – Commercial Health Insurance.....	7-1
Noncompliance Denials – Commercial Health Insurance and Medicare.....	7-3
Determining Third-Party Liability- Commercial Health Insurance and Medicare	7-3
Time Limit Override on Third-Party Insurance – Commercial Health Insurance	7-5
Refunds to Medicaid – Commercial Health Insurance and Medicare.....	7-5
Personal Injury Cases.....	7-6
Tort (Personal Injury Liability)	7-6
Provider’s Rights in a Personal Injury Case	7-6
Billing for Personal Injury Cases	7-6
Payment for Personal Injury Cases.....	7-7

Refunds and Recoupments for Personal Injury Cases	7-8
Third-Party Liability—Frequently Asked Questions.....	7-8
Health Insurance Premium Payments.....	7-16
Payment of Health Insurance Premiums.....	7-16
Eligibility Determination.....	7-16
Qualifying Process	7-16
Medicaid Credit Balance Reporting.....	7-17
Completing and Submitting the Medicaid Credit Balance Report	7-17

Section 8. Resolving Denied Claims8-1

Claim Adjustments	8-1
Resubmission of a Denied Claim	8-1
Instructions for Completing the Medicaid Claim Adjustment Request Form	8-1
Tips for Filing Adjustments.....	8-4
RA Requirements for Paper Adjustments	8-6
Submitting an Adjustment Electronically	8-6
EOB Denials That Do Not Require Filing an Adjustment	8-6
Pharmacy Claim Adjustments	8-9
Instructions for Completing the Pharmacy Adjustment Request Form.....	8-11
Resolution Inquiries	8-11
Time Limit Overrides.....	8-12
Instructions for Completing the Medicaid Resolution Inquiry Form	8-14
Recoupments.....	8-14
Automatic Recoupments.....	8-14
Provider Refunds	8-16
Submitting Refunds with a Remittance and Status Report	8-16
Submitting Refunds with the Medicaid Provider Refund Form.....	8-16
Tips for Submitting Refunds.....	8-17

Section 9. Remittance and Status Report.....9-1

What Is the Remittance and Status Report?	9-1
Remittance and Status Report Sections and Subsections.....	9-1
Paid Claims.....	9-1
Adjusted Claims	9-1
Informational Adjustment Claims	9-2
Denied Claims.....	9-2
Claims in Process	9-2
Financial Items.....	9-2
Claims Summary.....	9-2
Claims Payment Summary	9-2

Financial Payer Code.....	9-2
Population Group Payer Code	9-3
New Totals Following the Current Claim Total Line	9-3
Summary Page	9-4
Tax Information	9-4
Remittance and Status Report Field Descriptions.....	9-4
Explanation of the Internal Control Number	9-6
Explanation of Benefit Codes.....	9-8
How to Request a Duplicate Remittance and Status Report.....	9-9
Section 10. Electronic Commerce Services	10-1
Available Transactions	10-1
Electronic Claims Submission.....	10-1
Improved Cash Flow	10-1
Saved Time.....	10-2
Ease of Use	10-2
Support	10-2
Billing Claims Electronically	10-2
Trading Partner Agreements.....	10-2
Billing with the North Carolina Electronic Claims Submission Web Tool.....	10-2
Billing with Software Obtained from a Vendor.....	10-2
Billing with Software Written by Your Office or Company	10-3
Billing through a Clearinghouse	10-3
Value Added Networks	10-3
Interactive Recipient Eligibility Verification.....	10-4
Approved VAN Vendors.....	10-5
Important Telephone Numbers for Electronic Commerce Services	10-5
Electronic Funds Transfer.....	10-6
Electronic Commerce Services—Frequently Asked Questions	10-6
Section 11. National Provider Identifier	11-1
What Is the National Provider Identifier?.....	11-1
The NPI and N.C. Medicaid	11-1
Atypical Providers	11-1
NPI and Provider Enrollment	11-1
Obtaining the NPI.....	11-2
Reporting the NPI	11-2

NPI Subparts	11-2
Taxonomy and NPI	11-4
Unknown NPI Report	11-4
Unresolved NPI Report	11-5
NPI and the Automated Voice Response System.....	11-5
NPI Effects on the Remittance and Status Reports and the 835 Transaction..	11-5
NPI and Claim Submission Guidelines	11-7
NPI and Carolina ACCESS	11-7
Electronic Mailing List for NPI Updates.....	11-7
NPI—Frequently Asked Questions	11-7
General Questions.....	11-7
Applying for Your NPI	11-9
Reporting your NPI to N.C. Medicaid.....	11-9
Updating and Verifying Your NPI with DMA Records.....	11-11
Carolina ACCESS.....	11-11
Taxonomy Codes.....	11-12
Filing Claims	11-13
Other	11-16
Appendix A: N.C. Medicaid Automated Voice Response (AVR) System ...	A-1
Appendix B: Contacting EDS—Telephone Instructions.....	B-1
Appendix C: Contacting Medicaid.....	C-1
Appendix D: EDS Provider Services Representatives.....	D-1
Appendix E: List of Abbreviations	E-1